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ABSTRACT

This monograph is written to convey the point that the aged are ill-served by people's negative attitudes and by youth-centered social systems. It is designed for individuals who are aged as well as those who work with aged relatives or friends. It will also be useful as preparation for training programs or discussion groups, as well as for those who desire a relatively brief summary of current thought in gerontology. (Author)

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*The Social-Psychological Aspects of Aging

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Introduction

The present monograph is written in two parts by two different individuals; not because we believe that disciplinary boundaries are important, but rather because we found them to be convenient. Hopefully, you will find the two sections useful and helpful in your own thinking about aging.

I have intentionally avoided documentation as this monograph is not meant to serve scholarly needs, but rather to convey a point, to make an argument, which may be beyond documentation: that the aged are ill-served by our negative attitudes, and our youth-centered social systems. None of the points made are original; they have all been made by others at other times. Perhaps one should view the present monograph as a written lecture where we did not want references to distract from the line of thought. Such is not to say the points are not documentable: they are all to be found in the professional literature.

We think this monograph will be most useful for, and indeed we designed it for, individuals who are aged and individuals who work with an aged friend, relative, or volunteer workers who desire a relatively brief summary of current thought in Gerontology. The monograph may be convenient, and hopefully useful, as preparation for training programs or discussion groups. These suggestions for its use are not meant to suggest these are its only uses. The reader may hopefully find many other uses for it. (Keeping warm in the winter?)

Acknowledgements

The present document is essentially a written version of a training session given by myself and David Larson as part of a Title IV--A Training Program conducted in Allegany, Cattaraugus, and Chattauqua counties in New York State during 1976. The sponsorship of the New York State Office for the Aging, the County Office for the aging in each of the three counties and the Directors of the County Offices, Shirley Greiff, of the Allegany County Office, Sven Hannan, of the Chattauqua County Office, and Marilyn Gibbon and Kathy Horner of Cattaraugus County, and Alfred University is greatly appreciated. Thanks are due all individuals, agencies, and institutions who supported this activity. I was the principal investigator on the grant, the co-investigator was Charles McConnel. More than any others, our greatest debt is to the aged citizens in these counties and elsewhere for teaching us so much. If the monograph is useful, all thanks go to these groups for making it possible. If there are faults, and indeed there are, the blame is mine. At any rate, we tried!

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Psychological Aspects of Aging

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Aging, as we are experiencing it currently, is a recent phenomenon occurring mainly in technologically well developed countries. In 1900, in the United States, the average life expectancy at birth was 50 years. By 1969 the average life expectancy in the United States was 70 years. As the average life expectancy for an individual is based upon the average life-span of individuals born, the infant mortality rate will markedly affect such an average. Thus, a major statistical contributor to the increased life expectancy has been marked reductions in the infant mortality rate. However, such a reduction in infant death is only one contributor to increased life expectancy. Better control of diseases at all ages has also contributed to an increase in the average life-span.

Accompanying medical advances in preventing the deaths of young people has been a reduction in the birth rate in the United States. The reduction in birth rate combined with medical advances has led to an increasing proportion of the population in the aged category. In 1900 the aged constituted four percent of the United States' population. In 1970, ten percent of the United States' population was over the age of 65 years. By 2,000, depending on the assumptions one is willing to make about medical advances and birth rates, the aged will constitute 12-16 percent of the United States' population. Thus, we are confronting a situation in which increasing numbers of individuals are surviving longer, and the aged portion of the population in the United States is increasing its size relative to its own past size and relative to other age groups.

When talking about the aged, we are generally referring to individuals over the age of 65 years. The age of 65 is itself relatively arbitrary; sixty-five is the age of retirement as defined by the 1935 Social Security Act. Actually the age of 65 comes to us from Otto Von Bismark in Germany who in 1882 decided that, due to the rising employment problems of younger Germans, older Germans ought to leave the work force at the age of 65 years. It is clear that there is nothing magical or scientifically meaningful in establishing such an age as the age of retirement. Is a person suddenly transformed from a productive worker at 64 to a non-productive worker at 65? Why not 55? Why not 75? There is, in fact, much data to indicate that older workers are better workers. Nonetheless, the age of 65 is well entrenched as the age at which a person becomes a senior citizen, more by its use as the age of retirement, than by any reasonable criteria.

The above information is presented so that the reader will understand the lack of experience we have with aging on the scale it is occurring in the contemporary United States, and why we are necessarily re-evaluating our former misconceptions about the aging process and the aged individual. Better health care, increased education, and expended knowledge make aging a different experience for both individuals and the society than it was in former times.

The present paper is an attempt to give the reader current knowledge about aging and to refute stereotypes and misconceptions based upon formerly limited experience with the aging process. Specifically, we will focus on what social scientists and Gerontologists have contributed to our changing views of aging. Clearly it is difficult, if not useless, to draw disciplinary boundries on the study of Gerontology. Psychologists,

Psychiatrists, Medical Doctors, Sociologists, Anthropologists, Economists, Biologists, and Political Scientists are but some of the disciplines which have contributed to our knowledge of aging. Perhaps more than most areas, Gerontology has been problem centered rather than discipline centered.

There are no real theories of aging comparable to contemporary theories of child development. Rather, researchers approach the study of aging with a few loosely examined assumptions or models of aging (one exception to this is the recent work on dialectical theories of life-span development as articulated by Riegel and others.) Two contrasting models at least implied in most Gerontological research are the decrement model and the compensation model. Both of these models suggest changes with advanced age but differ in their attribution of the sources of change. The decrement model suggests inevitable biological decline, while the compensation model suggests that decline, where observed, is as much a function of the older person's environment as it is of biological changes in the individual. The implications for social programming and policy is quite different between these two loosely formulated models. The decrement model suggests a kind of inevitable, non-alterable, state. The compensation model suggests that we all need different sorts of environments as a function of our age and state; by providing a supportive environment the so-called biological decline may be compensated for, or minimized, if not actually delayed.

Whatever model one finds most useful, one fact that becomes clear from the research data is that the age group to which an adult human being belongs is a poor indicator of the individual's intellectual, personality, or emotional characteristics. As with sex, Ethnic group and

other such categories, age tells us little else about the individual. Does being 65 years old suddenly change a worker from productive to non-productive? Does being older make one less intellectually competent? Should knowledge of an older individual's age override other factors in the medical diagnosis of physical and mental disorders and lead to the diagnosis of "old age"? Perhaps one of the most important generalizations from the psychological research on aging is that how long a person has lived is less important than what the individual has been doing during those years.

One of the purposes of the present paper is to question stereotypical attitudes about aging and the aged, particularly those negative and invidious views based on outdated notions about aging. Such attitudes have undoubtedly contributed their own share of truth to the aging process via the well known self-fulfilling prophecy. For example, the lowered self-image of the aged is a very pervasive finding in gerontological research, and very likely a result of attitudes held by the wider society toward the aging process. In fact, a recent Lou Harris poll (1975) indicated that the aged themselves were as likely as young people to stereotype other aged persons. (Such negative views of other aged individuals by the aged individual undoubtedly contributes to a lack of social and political cohesiveness among the aged.) Actually, the research findings are often more optimistic than our common beliefs.

Much of early research in gerontology tended to support stereotypical views of the aging process by reporting losses in such areas as intelligence, problem solving ability, motor coordination, and learning ability with advancing age. More importantly, such decrements were viewed as an

inevitable accompaniement of aging which would occur in all who grew old. More recent gerontological research suggests that what once was viewed as an inevitable accompaniment of the aging process may, in fact, be more properly identified as a consequence of social change which has benefitted younger cohorts more than older cohorts. Thus it is not age, but social change which has often caused the aged to perform less well than young people. For example, greater access to education and better medical care are but two social factors which have benefitted the present cohorts of young people more than present cohorts of aged individuals. Therefore, the experience of current generations of aged persons may be quite different than the experience of future generations of aged persons. Such differences may be due to social change. It would be naive to argue that there are no changes with advanced age, but the assumption that these changes are inevitable, or cannot be compensated for, is not supported. In fact, environmental support may be a primary way of minimizing the impact of changes which are seen as associated with advanced age.

The thrust of social policy for the aged ought to deal with the circumstances which enable the older individual to perform in an optimal fashion, with dignity and independence. That we have constructed a youth-oriented society is hard to deny. (The term ageist is used to refer to this neglect of the aged.) The environments we build are for young people to the detriment of the olders. Thus, it is largely from the perspective of a hostile and non-supportive life-space, constructed by and for young people, that the aged are markedly disadvantaged. Recently there has been an emphasis in gerontology on examining ways to maintain function in the aged, on looking at things the aged can do, rather than

chronicling the decline caused by neglect and stereotypical attitudes that lead us to see old age as series of inevitable losses.

As has been alluded to, most of the gerontological social science research suffers from a severe methodological defect: it consists of comparisons of the present day young with the present day aged. We know there are things these generations differ along in addition to age, e.g., education, media exposure, and medical care. Such considerations must make us very cautious in concluding that differences between the young and old are due to age. It must make us even more cautious in predicting from present generations of aged to future generations of aged. These differences due to social-historical factors are referred to as cohort differences rather than age changes. This distinction is important to keep in mind anytime comparisons are made between present day young and old individuals.

A second, and equally important, consideration in looking at age differences and age changes in older age groups is to separate aging effects from effects due to disease. While it is apparently true that the aged are more susceptible to disease than the young, one must be careful not to confuse the relatively healthy aged with the ill aged. Many effects formerly thought to be an inevitable product of aging are turning out to be caused by disease processes rather than the aging process. The control and prevention of such disease may eliminate many losses currently associated with advanced age.

A prime example of the joint operations of a cohort effect and a disease effect causing loss is in the area of intellectual functioning. Number of years of education has been shown to be related to intelligence

in old age such that those with more education seem to maintain their intellect into old age. In addition cardiovascular insufficiency and high blood pressure has been shown to be a prime cause of intellectual loss in old age. When the blood pressure is reduced, there is often a remarkable recovery of function. To complicate matters a bit, it has also been found that a high stress life style, known as the type 'A' personality, is most likely to lead to cardiovascular disease, irrespective of diet, smoking and so forth. Thus we have an example of behavior altering physiology which then alters behavior. Such is a much more complicated situation than inevitable biological decline with advanced age. Further, the assertion that changes in old age are a reflection of what a person has been doing all those years rather than age per se, has found additional support in the case of intellectual functioning.

Related to the above, it has often been assumed that physiological changes in old age are irreversible. Such an assumption is largely without support and represents another form of ageism. The technique of biofeedback suggests that even physical functions once thought to be beyond voluntary control are, in fact, capable of being brought under voluntary self-control. Biofeedback refers to the electronic monitoring of a physical function such that the individual can be given immediate feedback on how the function monitored is operating. The individual is then, through various methods as yet poorly understood, able to alter that function or control that function. Biofeedback has been used successfully to control blood pressure, heart rate, skin temperature, brain wave patterns as well as other functions of the so-called autonomic or involuntary nervous system. Biofeedback may hold great promise for altering

physical function in the aged. It has been demonstrated thatolder individuals may learn to control blood pressure, heart rate, and brain wave activity. Interestingly, older individuals learned to control their brain wave activity more rapidly than younger persons. Currently investigators are attempting to determine if such control over nervous system activities can be utilized to compensate for age related changes in cognitive--intellectual functioning in aged individuals.

Related to the psychophysiological aspects of aging is the mental health of the aged. A common finding here is that psychopathological disorders occur at the highest rate in the over 65 age group. In fact, the rate is often estimated to be twice that of the next most susceptible age group. One of the most common forms of mental disturbance in the aged is depression. Thirty-five percent of the known suicides in the United States occur among individuals over the age of 65 years (10 percent of the United States' population is 65 years of age or older). Why is depression the common cold of mental health in the aged?

In all ways it seems that the aged have the odds against them; change and loss may become dominant themes in their lives. Environmental losses are tangible causes of depression: loss of spouse, loss of friends, loss of employment and employability, loss of status, loss of income, loss of physical strength and loss of meaningful activity. While there is some evidence of an alteration in the chemical makeup of the aging brain associated with depression, it is not clear if such changes are a cause or a consequence of depression.

Recent psychological research suggests that some forms of depression are a consequence of the perception that one has little or no control over

one's environment, of being unable to control the contingencies and outcomes of behavior. Such a circumstance may be particularly depressing where one experiences many negative and punishing consequences. This phenomenon is referred to as "Learned Helplessness." Thus, circumstances where control is removed from the individual are likely to result in depression. Most long-term care facilities, where control is with the staff, create a helpless and hence depressed resident. The solution to this sort of depression is to restore reasonable control over their own lives to the individual. Social policy ought to be directed toward restoring control to the aged individual. The absence of monetary resources is in effect a stripping away of individual control. My own readings of the literature on the post-retirement years leads me to the conclusion that income is highly related to satisfaction in the retirement years. Thus, adequate resources may mean adequate control and autonomy and hence a relative absence of mental depression. Clearly income alone cannot account for depression but it is nonetheless an important factor.

Related to the issue of depression in the aged is a symptom(s) commonly associated with old age in the public mind, and in the mind of professionals who deal with the aged. This symptom is mental confusion, disorientation for time and place, often referred to as "senility." Senility is not a psychiatric or medical diagnostic category. It is rather a wastebasket term with very unfortunate implications for the aged individual so labeled. To label all mental confusion in aged persons as senility is cruel and irresponsible with its erroneous implications of hopelessness, irreversibility, and inevitable association wiht the aging process. While senility is not a diagnostic category, it is diagnostically

often called Chronic Brain Syndrome or Senile Brain Disease. In the absence of compelling physiological support these diagnoses should never be made. The label chronic implies irreversibility and hence hopelessness. More likely, mental confusion is often due to depression or a transient brain state (Acute Brain Syndrome). Too often these diagnoses are made just because the individual is aged. Then, the individual is placed in an institution or returned home as untreatable, as suffering from old age.

Recent research suggests that many geriatric patients admitted to institutions as suffering from Senile Brain Disease (and related diagnoses) were, in fact, suffering from an Acute Brain Syndrome. Let us note here that the aged are more susceptible to environmental assaults, disease and infection, due to, among other things, lowered immune response. Along with this susceptibility goes a tendency to be affected more severely than young people by those disorders. Thus an Acute Brain Syndrome in the aged has been shown to be caused by such factors as vitamin deficiencies, infections, high blood pressure, cardiovascular disease, anemia, fecal impaction, alcohol, and the side effects of prescription drugs (particularly barbiturates). (Mental depression has also been related to mental confusion in the aged.) Acute Brain Syndrome has been shown to be quite treatable in old age. The real tragedy begins with the failure to treat. Such is another example of ageism in our society. The relegation of the aged person suffering from a treatable disorder to custodial care and its institutional variations, and chemical strait-jacketing, only further demonstrates the loss of control accompanying the loss of resources and the consequences of ignorance in the larger

society.

In many cases we observe the attitudes in professionals that a psychiatrist-gerontologist has called "Therapeutic Nihilism." Therapeutic Nihilism refers to the view that the aged are untreatable, that they are not worth wasting valued resources on, and that they are going to die anyway. Why bother? Aside from the moral and ethical implications of such a view, it constitutes a shocking disregard for the human involved and for common sense. We are all going to die; that is part of life and living! There is substantial evidence that the aged have great strength and are very treatable. Our Western inclination to see death as making life meaningless is a costly view, particularly in the case of the aged, where death is indeed a greater reality. The quality of life is often ignored to focus on the quantity of life.

Related to ageist views of mental disorders in the aged is the view that cognitive-intellectual decline is equivalent to old age. Early research suggested that indeed intelligence test scores dropped in old age. Unfortunately or fortunately (depending on whether you identify with the researchers or your own old age), the methodology utilized to collect this early data consisted of utilizing different individuals of different ages, e.g., comparing a 65 year old in 1950 to a 20 year old in 1950. Thus, not only did these people differ in age, but they exist and were reared in very different social-historical circumstances (a cohort effect). Clearly one could not know from such a method whether observed differences were due to age or better and more education in successive cohorts (on some other such social factor). In fact, those studies which have followed the same individuals over an extended period of time

have found that inevitable intellectual decline is not inherent in the aging process. Where such decline is observed it is often found to be a product of inactivity, disease processes, and/or psychological disturbance. Nowhere has aging been found to cause intellectual decline!

We are not really doomed to inevitable intellectual decline. The real issue is more likely obsolescence! We make the aged individual obsolete by failing to provide incentives, educational opportunities, and vocational possibilities to the older individual (indeed the process often starts in middle-age). Our educational institutions, with some recent exceptions, seem preoccupied with 18 to 21 year olds. "Why bother with the aged? They're only going to die anyway! And besides, you cannot teach an old dog new tricks." You will recognize what we may call Educational Nihilism, to fit with our earlier therapeutic nihilism. In fact, again, research by psychologists suggests that the aged not only learn well, but benefit by education. At any rate, we can deal with obsolescence. Inevitable biological decline as an attitude, seemed so hopeless.

Much current research in psychology adds further support to the relative futility of viewing old age as synonomous with loss of intellect. Where lowered intellectual performance is observed it is often casued by situational and environmental factors which work to the disadvantage of the aged. Thus, where such lowered performance is observed, anxiety, fear, and some personal style variables have been shown to reduce the performance of the aged. In our youth-oriented society the advantage, environmentally, goes to the young. Intellegence tests devised for the young may, in fact, be inappropriate for use with widely separated cohorts.

Another area of interest to gerontologists, and of obvious interest to the aged, despite our stereotypes to the contrary, is the maintenance of sexual response anf function in the aged individual. One researcher has referred to our social stereotype as "the myth of the sexless aged." The myth asserts that sexuality is not characteristic of the aged and, so it goes, that is the way it is supposed to be. Here we encounter a double threat; aging and sexuality. Parents refuse to admit that their children do it, children cannot admit that their parents do it, and parents and children are unable to admit that their grandparents do it. But everybody is doing it! The research on sexuality, all the way back to the early Kinsey survey data and through the more recent and popular work of Masters and Johnson, confirms that all are "doing it." Sexual expression has been, and but for our ageist stereotypes, always will be a life-long possibility. Perhaps the view that human sexuality exclusively serves procreation, a rationale that eliminates the aged, contributes to our view of the sexless aged. But, if you believe the data, sexlessness in the aged is mainly a youthful fantasy (perhaps fear).

While research suggests a decline in frequency of sexual outlet with advanced age, it is the rule for sexual interest and activity to continue, where such is possible. Typical research findings here suggest that the pattern of sexual activity in the older years is a continuation of earlier patterns. While absolute frequency may decline, the relatively more active young people will become the relatively more active old people. By no means in the absence of disease, is there a sudden cessation or decline in sexual function or expression. Again, here as in other areas, disuse is the enemy of maintained function. Social attitudes which label

such activity as inappropriate or uncharacteristic are not only unfairly discriminatory, they are wrong! Ignorance on the part of those who deal with the aged only creates guilt and discomfort surrounding sexuality.

Not only is maintained sexuality a potential reality for the aged, but it ought to be actively supported both in and out of institutions. Some researchers have noted the beneficial effects of continued sexuality in the aged. It aids in reducing arthritis pain through the release of natural cortisone during sexual activity, and it is a form of exercise which may assist in general bodily maintenance. Psychologically, how can we measure the obvious benefits of warm human contact and stimulation to our feelings about ourselves? Some researchers have noted the neglect of this important area by professional health care personnel. Frequently guilt over masturbation and continued sexual interest is seen in the aged. Professionals (as well as others) have often been found to encourage such guilt with inappropriate moralizing, neglect, and prejudices about sexuality.

In this section of this monograph I have selected and targeted but a few of the potentially numerous areas to demonstrate the harm of negative stereotypes and prejudices toward those of us currently aged and those of us who will survive to be aged. That these prejudices will create their own truth is more than just possible, that they are contrary to the evidence is compelling. Perhaps it is because of our limited social history as an aging society; perhaps it is our need to equate youth with goodness, beauty, and cleanliness; or maybe because of our lack of compassion, for whatever reason the human experience is too great to continue as we have in our treatment and stigmatizing of an individual based on age. Age differences and age changes are not a myth, but neither

are they as we once thought: biologically inevitable, irreversible, and uncontrollable. We must be realistic about aging, it is not for sissys! But if reality is any guide, neither need aging be dreadful.

> Perhaps it is as the late psychoanalyst Carl Jung once stated: "We cannot live the afternoon of life according to the program of life's morning; for what was great in the morning will be little at evening, and what in the morning was true will at evening have become a lie."

The realization of Jung's words may not only be helpful in altering our ageist attitudes, but may constitute successful aging.

SOCIAL ASPECTS OF AGING

Many people perceive their present life situation as primarily their own creation. This is especially true for Americans with our high regard for individualism and freedom. Success or failure, happiness or sadness, are viewed as results of one's own intelligence, skill, effort and perhaps luck. In reality, however, social forces, often invisible, impinge upon the lives of everyone. Demographic shifts, industrialization, wars, migration, technological change, mass education, unemployment, and changing social values intrude into the life space of all and leave their mark. What is true for individuals is perhaps more so for groups or aggregates of people. The aged in America are no exception; social processes and social change affect all aspects of the lives of elder citizens.

Demographic Factors

Demographic characteristics, such as the number of people, their composition, and rates of change, are significant social factors that influence the aged. In 1974 there were 21.8 million Americans age 65 and over. Making up this group were nine million men and 12.8 million women. In other words, for every 100 women there were only 70 men. To the extent that marriage and male-female companionship are important to the aged, this sex ratio imbalance has obvious ramifications for elder women. If the same proportion of men and women over age 65 wish to be married (monogamously), approximately 30 percent of the women would not have an available partner no matter how personally desirable they might be. This illustrates our earlier point that social factors influence individuals in a direct manner. This sex ratio imbalance is not expected to improve. In the year 2000, of the estimated 30.6 million Americans who will be age 65 or over, 12 million will be men and 18.6 million women. For every 100 women there will only be 65 men.

Additional significant demographic variables are the total number of people over 65 and their proportion of the total population. In 1900 there were approximately three million age 65 and over, about four percent of the total population. By 1974 the 21.8 million older citizens made up 10.3 percent of the total. Assuming a stable population (zero population growth) in the years 2025-2050, it is estimated there will be approximately 45.8 million people age 65 or over, about 17 percent of the total population. Estimates of the total number of older people for the future is relatively easy since most of the prople are already born and can be counted. However, estimates of the proportion of the total population varies with changes in the birth rate and migration which are harder to predict.

The increase in their number and proportion has mixed consequences for the aged. When the aged are few in number they are generally revered and honored. However, when the size of the aged population expands they are more likely to be viewed as a growing economic and social burden. An example is the change underway in India

reported in a recent New York Times article. Old people used to be relatively uncommon; a child born in 1947 was not likely to reach the age of 40. Now, with better sanitation and medical care millions are living past 65. This has brought a marked strain on the traditional extended-family system in which adult children are expected to take care of parents within their home. However, a recent study reported that 30 percent of the elderly have been forced to move because they lived longer than anyone anticipated. This change in India duplicates similar changes that have already occurred in the developed world.

On the positive side, the growing number of aged could become a significant political force. In a democracy votes carry power to redress life situations. Senior citizens are not yet organized as a political block, but the potential remains. Thus, the effect upon the aged of their increasing population is both positive and negative.

Social Change

Industrial and technological change has also had an inconsistent impact upon the aged. The higher standard of living that industrial and technological changes bring enhances the general welfare of all or most groups including the aged. Highly productive societies are able to support retirement and pension programs for elder citizens. On the other hand, one's importance and capacity as a worker generally declines in the later years of life in an economically developed society. Physical strength and coordination wanes with time; rapid social change places a premium on new knowledge and the latest techniques. Older workers are at a disadvantage when the economy is organized in a highly formal manner. The standardized routines of bureaucratic organizations do not adjust to meet the personal capacities and needs of particular groups of workers. The growing practice of mandatory retirement indicates the marginal position of older workers. Thus, from the point of view of the aged, technological change both contributes to and erodes away certain aspects of their life situation.

The process of urbanization has also affected the aged. Most urban areas have been marked by flux and movement as different groups shift their residence. The suburban explosion and the decline of inner cities has meant the destruction of many urban neighborhoods with their sense of community and social support. To be detached from one's community and social networks would be disorienting to anyone but especially so for those with the longest ties - the older people. The placed of the aged is likely to be strongest and best protected in family-centered traditional societies and weakest in a rapidly changing urban environment.

The accelerating rate of social change also seems to work to the disadvantage of the aged. Social change has at least two major components - material and non-material. Material changes are visible and everyone is familiar with them. Jet travel, atomic bombs, TV,

superhighways, heart transplants - the list is endless - have become realities only in the last few decades. Non-material social change occurs in the areas of beliefs, ideas, values, norms (expected behavior), and social relationships and are harder to deal with often because we are relatively unaware of them. When social change is slow, most people are able to keep abreast of what is expected. The things learned as children and young adults remain valid guides for one's later years.

In a rapidly changing society, however, many people often find themselves in unprecedented positions for which they are not prepared. Their past experience is no longer a guide; social norms no longer apply. The problem of adapting to social change by middle age people is illustrated in the statement by Janet Harris, "We were born in an era in which it was a disgrace for women to be sexually responsive - we matured in an era in which it was an obligation". Adjusting to changing sexual expectations is difficult enough, but it should be kept in mind that such changes are occuring in other areas, such as religion, politics, work, and education, at the same time which together compound the problems of trying to adapt to a new social order. This state has been called "future shock"; the future comes too quickly and leaves people in a state something like shock. Of all the age groups in society, the aged are perhaps least likely to cope adequately with future shock. In the extreme many elderly live out their lives in a world they no longer know.

American values and ideals generally work against the aged. We think of ourselves as a young nation where doing things, growing, and progress are glorified. Our stress on active striving and mastery of external reality makes adjustment to retirement and old age difficult. America is very materialistic and places a heavy emphasis upon sensual enjoyment and physical activity. The ability to participate in such activities generally diminishes as one grows older. Activities such as contemplation and mediatation, which could be pursued regardless of physical vigor, have not been cultivated by Americans and are not highly regarded. The cultural heroes are young and active; there are no counterparts for the old and wise.

Family

The social position of the aged is linked to the structure of the family, which has been gradually changing in Western society over the past century. Although this change is usually described as the isolation of the nuclear family (i.e., parents and their children), perhaps it may be more accurately described as the subdivision into two or even three generations of distinct nuclear families: young couple with their dependent children, the middle-aged parents, and the aged generation of grandparents.

As life expectancy has risen, husbands and wives have become increasingly likely to survive together into old age; and widowhood, even if not curtailed in length, has been postponed. Today, in such countries as the United States, Great Britain, or Denmark, in the

65-and-over age range, most men (about two-thirds), but a minority of women (about one-third), are living with their spouses. Moreover, most of those 65 and over, the married and even the widowed, maintain independent households. This way of living has been increasing in America as decreasing proportions of older people live in the same household with their children. Living entirely alone is a frequent pattern among older people. This is especially true among women where one of four (mainly widows) live alone. Thus a new type of nuclear family, the independent, older family (often a single-person family) is developing. The consequences of this change for the older person and for society as a whole have not been explored.

Social Roles

Like many other concepts, role is used in many different ways by various writers. Generally a role consists of those behaviors typically performed by an individual in a particular situation. In other words, a role is the expected behavior for certain categories of people. Two fundamental dimensions for dividing humans are age and sex. If a person is a male they are expected to "act like a man". Women are expected to "act like a lady", and we are all expected to act our age. Family membership locates us in a cluster of roles where expectations flow in several directions. A husband-father has obligations to his wife and children, and they in turn are expected to do certain things for him. Occupation or work is a role. Doctors are expected to heal with a kind, bed-side manner, clergy are expected to act godly, and presidents are expected to lead. There are many other roles: being sick, marital status, member of an organization, etc. A stigma is attached to some roles like deviant, alcoholic, divorcee, and mentally ill.

Roles are extremely important in the lives of people. Roles organize a person's daily routine and form the basis of a sense of identity. Our sense of self, or self concept, is a composite of our multiple roles; we think of ourselves in terms of the roles we play. It follows that changes in roles or the loss of a role affects our self concept, the sense of who we are. Drastic change in roles can be very disorienting to the persons affected.

The older the individual is (beyond the middle years), the fewer roles he plays on the average (as he retires from work, his children leave home, and his age peers die off) and the fewer and less varied are his contacts with other people. However, the aged do vary considerably in the degree to which they retain their major family and occupational roles. Some never retire from their life's work while others retire early.

Once older people have retired, they seem on the whole to accept the new role of retired person although many say that they regret losing their work associates, the feeling of usefulness, and the work itself. For a minority retirement can be a source of personal disorientation and trauma particularly if it is a forced retirement from a job one had invested a major part of their life and personality.

For such people their work was their life, and when forced from it, they lose a major component of their sense of self and the life organizing rhythm of their work place.

Old people play a variety of family roles and they seem no less likely than younger people to feel satisfied and adequate both as spouse and as parent. For those older people who have a living spouse, the marital relationship is of central importance; but, many of the aged, especially women, must adjust to widowhood at some time. The death of a spouse beyond being a great personal loss is also the loss of a major integrating role. The major role of wife around which a woman may have organized her life, is lost with the death of a husbnad, and adjustment may be very difficult.

Major Issues

One of the major issues in the sociological study of aging concerns the competition between engagement and disengagement theories of aging. Y. Talmon notes that the study of aging was dominated for a long time by a theory of engagement which assumed that old age does not differ much from middle age. It asserted that most aging people resent the role loss imposed on them by society and resist the shrinkage of their social world. According to this view, the best way to avoid the adverse effects of aging is to continue to maintain the level of activities and the associates of middle age as long as possible and to find suitable substitutes when forced to relinquish preaging patterns. The keys to optimal aging are activity, outgoingness, and involvement.

The theory of disengagement discards the view of old age as an extension of middle age. Aging leads to a triple withdrawal from society: a loss of roles, a contraction of relationships, and a decline in commitment to norms and values. Thus the aging person becomes increasingly egotistical - relaxation, comfort, and self-gratification are his main preoccupations. Cumming and Henry argue that disengagement is an intrinsic developmental process inherent in aging as such and not just a result of external social pressures. Withdrawal is seen as functional for the individual as well as for society, in that it prepares the aging person for his approaching final withdrawal and minimizes the effect of his death on his social ties.

Neither engagement nor disengagement theory seem totally adequate, for clearly both processes can be observed in any aged population. One factor is the considerable difference between the first and the last stages of aging. The onset of aging is often accompanied by an upsurge of activity and involvement, whereas the downward trend dominates during the later stages. Another factor is that engagement varies by sphere of activity. Religious and political activity remain high or even increase, while economic and family involvement declines. Both theories have been useful, but they and other approaches will continue to evolve as we learn more about the social aspects of growing older.

A second major issue in the sociological aspects of aging, according to Y. Talmon, is the controversy between the adherents of "community integration" and those of "age-group segregation". Classification of living arrangements of old people from the point of view of their opportunity for contact with members of other age groups and with each other yields a continuum ranging between maximal residential integration to maximal residential segregation. Scrutiny of the literature reveals that there is a fairly widespread rejection of the two extreme solutions: three-generation households are regarded as incompatible with the values and structure of the modern family, while there is growing opposition to closed and isolated homes for the aged.

However, we find controversy with regard to the intermediate patterns. Two seemingly opposed viewpoints have emerged in this sphere. Upholders of the age-heterogeneous pattern continue to put the main emphasis on intergenerational community integration. They hold that intergenerational relationships with kin are the main axis of the social integration of the aged. Living on their own in a "mixed" neighborhood in which they are long-term residents, with children or other close kin within easy reach, is considered to be the optimal solution.

Advocates of semi-segregated residential settings hold that relationships with age peers are the major axis of social integration of the aged. They point out that the semi-integrated pattern works only in cases in which the aging person is a long-term resident in a relatively homogeneous and stable neighborhood and as long as his network of informal relations is localized and fairly intact. A partly segregated age-homogeneous setting maximizes opportunities for contacts with peers and protects the aged from invidious evaluation yet at the same times does not cut them off from outside contacts. In summary, both points of view can be effectively argued, and public policy will have to consider both.